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RESEARCH

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Estresse e *coping* em familiares de pacientes no transoperatório de cirurgia cardíaca

Stress and *coping* among patients' relatives in the transoperative of cardiac surgery

Estrés y *coping* de los familiares de los pacientes en el transoperatorio de cirugía cardiaca

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ABSTRACT

Objective: to evaluate stress and *coping* among relatives of patients in the perioperative cardiac surgery. **Method:** it is a quantitative, analytical and cross-sectional study developed in a postage hospital IV, with 53 relatives waiting in the waiting room of the surgical center. Data were collected between March and April 2013 through a socio-demographic questionnaire and Symptom Inventory of Stress and Coping Inventory of Jalowiec. A Research Ethics Committee, approved the research project, number 198.527. **Results:** 60% are women, aged between 18 and 58 years old, married, with children, catholic, most of them daughters of patients. As for the stages of stress, 60% were in the intermediate phase and the majority used the sustaintive *coping* style. **Conclusion:** the results may support health professionals - researchers and managers - and mobilize integrated actions towards qualified assistance in the perioperative, with emphasis on care to patients and families.

Descriptors: psychological stress; psychological adaptation; family; thoracic surgery; nursing.

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RESUMO

Objetivo: avaliar estresse e *coping* de familiares de pacientes no transoperatório de cirurgia cardíaca. **Método:** estudo quantitativo, descritivo, transversal, realizada em um hospital porte IV, com 53 familiares que aguardavam na sala de espera do centro cirúrgico. Os dados foram coletados em março e abril de 2013, por meio de formulário de dados sociodemográficos e Inventário de Sintomas de *Stress* e Inventário de *Coping* de Jalowiec. Projeto de pesquisa aprovado por Comitê de Ética, Parecer nº 198.527. **Resultados:** 60% são mulheres, idade entre 18 a 58 anos, casadas, com filhos, católicas, sendo que a maioria é composta de filhas dos pacientes. Quanto às fases de estresse, 60% se encontravam na fase intermediária e o estilo de *coping* mais utilizado foi o sustentativo. **Conclusão:** os resultados podem subsidiar profissionais da saúde, pesquisadores e gestores, mobilizar ações integradas visando qualificar a assistência no perioperatório, com ênfase no cuidado aos pacientes e familiares.

Descritores: estresse psicológico; adaptação psicológica; família; cirurgia torácica; enfermagem.

RESUMEN

Objetivo: evaluar el estrés y afrontamiento de los familiares de los pacientes en transoperatorio de cirugía cardíaca. **Método:** estudio cuantitativo, descriptivo y transversal, desarrollado en un hospital del tamaño IV, con 53 familiares esperando en sala de espera del centro quirúrgico. Los datos fueron recogidos entre marzo y abril de 2013 con formulario sociodemográfico, Inventario de Síntomas de Estrés y Inventario de *Coping* de Jalowiec. El Comité de Ética en Investigación aprobó el proyecto, número 198.527. **Resultados:** 60% son mujeres, entre 18 y 58 años de edad, casadas, con hijos, católicas, y la mayoría es compuesta por hijas de los pacientes. En cuanto las etapas de estrés, 60% se encontraba en fase intermedia y el estilo de afrontamiento más utilizado fue sustentativo. **Conclusión:** los resultados pueden apoyar los profesionales de la salud, investigadores y gestores, movilizar acciones integradas para la asistencia de clasificación en el perioperatorio, con énfasis en la atención a pacientes y familiares.

Descriptores: estrés psicológico; adaptación psicológica; familia; cirurgía toracica; enfermería.

INTRODUCTION

Cardiovascular diseases (CVD) constitute a major cause of death worldwide and integrate the chronic noncommunicable diseases (NCDs). In Brazil, they are considered a major cause of prolonged hospital staying and are responsible for the allocation of public resources in hospitalizations because the economic burden of these diseases has grown exponentially in recent decades.[1]

CVD have chronic nature and can be treated clinically or surgically.[2] The treatment aims to restore the functional capacity of the heart, in order to lessen the symptoms and provide the individual's return to normal activities.[2] In this context, although the clinical treatment of heart disease has progressed and the minimally invasive approach is found in rapidly expanding, cardiac surgery is the intervention of choice in many cases.

CVD can impact the lives of patients and their families in face of the numerous diagnostic interventions and invasive treatments that are needed. The confirmation of the disease disrupts the family and affects the care of all other components, since the family is an interconnected system in which each of its members has an influence on others.[3]

In addition, cardiac surgery postoperative (PO) is marked by the instability of the patient's condition, full of peculiarities, mainly because it is a period of critical care.[2] Thus, in the same way that the patient needs care, family also needs to be serviced. The anxieties, fears and uncertainties of the family challenge the nurse to handle the situation.[4] Thus, it is important for nurses to keep interaction, meet and conduct a proper approach to the family, so that a trustful relationship occurs and they become gradually a reference to family and patient.

Because it is an invasive procedure, patients who undergo cardiac surgery require intensive care of the multidisciplinary team in the perioperative period. Each and every surgical procedure should be considered at risk due to the aggression suffered by the human body. For this reason, it is for the team to consider that heart surgery will mix up the "center of life" and therefore the family involved in this context will have fantasies and fears related to death, inside violation, superstitions and insecurities.[5] However, the approach manner of the team will contribute to the achievement of satisfactory results or not, with results in morbidity and mortality.

The patients' relatives await news about the clinical picture and wait anxiously to know how their familiar is reacting to the procedure. Therefore, the nursing staff must keep the family informed about the progress of the surgery in order to minimize these feelings such as fear, anxiety, insecurity, stress, as well as include the family in the care and recovery of the patient. In this regard, the Code of Ethics of Nursing Professionals, in its article 17, provides for the responsibility and the duty to provide adequate information to the patient, family and community about the rights, risks, benefits and complications as to nursing care, possible risks and consequences that may occur.[6]

Assistance to families is important because they also assess the situation experienced by the patient as stressful and have cognitive and behavioral responses to stress. Stress is defined as any event that requires from the external or internal environment, that taxes or exceeds the adaptability of an individual or social system.[7] Thus, faced with a stressor a cognitive assessment must be performed, which is understood as a mental process of locating each event or situation in a number of evaluative categories that are related to the meaning of well-being of the individual.[7] Accordingly, the coping is understood as a dynamic and scalable process, defined as a cognitive and behavioral change to manage specific external and/or internal demands that are assessed as surplus to the individual resources.[7]

Thus, from these considerations, this study aims to evaluate stress and coping of family members of patients in the perioperative cardiac surgery.

METHODS

Quantitative, descriptive and cross-sectional study conducted in a hospital size IV with 53 family members of patients in the perioperative of cardiac surgery. These families were in the waiting room of the operating room and, by accepting to participate in the research, were taken to a private room near the Intensive Coronary Care Unit (ICCC) in order to foster dialogue between researcher and researched.

The study included family members who met the inclusion criteria, namely: to be a patient's familiar who was undergoing heart surgery, to be waiting in the waiting room of ICCC or surgery center, to be 18 years old or older and agree to participate in the study.

The data were collected in March and April 2013 through sociodemographic data form, Symptom Inventory Stress and Coping Inventory Jalowiec.[8-9] Data analysis was performed using the statistical software SPSS 15.0.

In the Inventory of Stress Symptoms, each family marked the symptoms they felt and the sum was obtained from the count of one (1) for each reported symptom. The way the instrument was built allows the same subject to be classified in more than one stage of stress. For the purposes of analysis, for each subject was considered the highest level reached to their classification as follows: a larger sum than or equal to eight symptoms classifies the family in the exhaust phase; a summation smaller than five ranks the familiar stress in the Initial Phase, and a sum equal to or greater than three classifies the family in the Intermediate Phase of Stress. Phases of stress, according this inventory are: F0 - Eustress or Stress Positive; F1 - Initial Phase of Stress or Alert Phase; F2 - Interim Phase or Stress Resistance Phase and F3 - Final Phase of Stress or Exhaustion Phase.

The Inventory Jalowiec Coping comprises 60 statements that, for examination, are divided into eight coping styles: confrontive (confront the problem directly - 10 items), evasive (avoiding the problem - 13 items), optimistic (have positive thoughts - 9 items), fatalistic (hopelessness about the problem and pessimistic - 4 items), emotional (responds emotionally - 5 items), palliative (get over the problem by doing things to feel better - 7 items), sustaintive (use bases to confront problems - 5 items), and self-confident (use strategies involving its own resources - 7 items). For data analysis, it was used the relative score, resulting from the sum of the values of all items scored in the subscale, divided by the number of items in the same (half score). After that, the scores for each subscale were compared, the one with the highest score was considered as the most used coping style.

The development of this study met the ethical principles attending the National Health Council Resolution 196/96.[10] The research project was approved by the Research Ethics Committee of the Regional University in the Northwest of the State of Rio Grande do Sul - Universidade Regional do Noroeste do Estado do Rio Grande do Sul, Embodied Opinion No. 198.527 and, all study subjects signed the Term of Free and Informed Consent (TFCI).

RESULTS

Table 1 shows the socio-demographic characteristics of 53 familiars of the patients who were in surgery.

Table 1: socio-demographic characteristics of the family members of patients during heart surgery. Rio Grande do Sul (RS), 2013.

Characteristic	N	%
Gender		
Female	34	64,2
Male	19	35,8
Age		
18 |--- 28 years old	4	7,5
28 |--- 38 years old	17	32,1
38 |--- 48 years old	14	26,4
48 |--- 58 years old	10	18,9
58 anos ou mais	8	15,1
Marital Status		
Married	32	60,4
Single	18	34,0
Widow(er)	2	3,8
Divorced	1	1,9
Scholarity		
Complet Basic Education	7	13,2
Incomplet Basic Education	21	39,6
Complet High School	11	20,8
Incomplet High School	4	7,5
Complet Higher Education	5	9,4
Incomplet Higher Education	5	9,4
Religion*		
Catholic	29	54,7
Evangelical	13	24,5
Other	10	18,9
Children		
Yes	37	69,8
No	16	30,2
Number of children*		
One	8	15,1
Two	17	32,1
Three	4	7,5
Four	3	5,7
Five or more	4	7,5
Kinship degree with the patient		
Daughter	15	28,3
Son	12	22,6
Wife	11	20,8
Husband	4	7,5
Sister	3	5,7
Brother	2	3,8
Other	6	11,3

Source: research data.

* n=52

Regarding the socio-demographic data of the family members the majority of them was female, and about the kinship degree with the patient, 28,3% were daughters.

Next, Table 2 shows the results for the coping styles used by the researched members at the time when their familiar was undergoing cardiac surgery.

Table 2: distribution of relative scores of the coping styles from relatives of patients in the perioperative of cardiac surgery. Rio Grande do Sul (RS), 2013.

Coping Styles	Most used		Less used	
	N	%	N	%
Sustaintive	27	50,94	-	-
Optimistic	8	15,09	-	-
Confrontive	8	15,09	1	1,89
Self-confident	1	1,89	-	-
Evasive	-	-	1	1,89
Fatalistic	-	-	30	56,60
Emotional	-	-	15	28,30
Palliative	-	-	2	3,77
Optimistic and Sustaintive	2	3,77	-	-
Confrontive and Sunstaintive	2	3,77	-	-
Sustaintive and Self-confident	1	1,89	-	-
Confrontive and Optimistic	1	1,89		
Confrontive, Optimistic and Sustaintive	3	5,66	-	-
Evasive and Fatalistic	-	-	1	1,89
Fatalistic and Palliative	-	-	2	3,77
Confrontive and Emotional	-	-	1	1,89
Total	**53**	**100,00**	**53**	**100,00**

Source: research data.

In this study 50,94% of families used the coping style Sustaintive, in which the person uses personal, professional and spiritual support systems to address the problem, and 15,09% the Optimistic and the Confrontive, respectively.[11]

The Optimistic coping style was used with a representative frequency (15,9%) by the population.[12] In the same frequency, Confrontive coping was used by 15,9% of the family.

Sequentially, Table 3 shows the crossing of coping styles according to the stress stages where the respondent families were at.

Table 3: relative score of the coping styles according to the respondent families stress phases of a general hospital/RS (n=53). Rio Grande do Sul (RS), 2013.

	Stress Phases			
Coping styles	**Eutress n(%)**	**Initial Phase n(%)**	**Intermediate Phase n(%)**	**Total n(%)**
Sustaintive	8(15,1)	4(7,5)	15(28,3)	27(50,9)
Optimistic	5(9,4)	-	3(5,7)	8(15,1)
Confrontive	2(3,8)	1(1,9)	5(9,4)	8(15,1)
Self-confident	-	-	1(1,9)	1(1,9)
Optimistic and Sustaintive	-	-	2(3,8)	2(3,8)
Confrontive and Sustaintive	-	-	2(3,8)	2(3,8)
Sustaintive and Self-confident	-	-	1(1,9)	1(1,9)
Confrontive and Optimistic	1(1,9)	-	-	1(1,9)
Confrontive, Optimistic and Sustaintive	-	-	3(5,7)	3(5,7)

Source: research data.

As for the stress phases the patients families were at that time, 60,5% were in the Intermediate Phase or Stress Resistance, 30,2% in Eustress or Stress Positive Phase and 9.4% in the Initial Phase or Alert. No family was in the Finals Phase of Stress or Exhaustion.

DISCUSSION

More than half of the sociodemographic data of family members are female and 28,3% were daughters of the patients. In this respect, historically, the role of the woman is caregiving, starting with the home, children, husband and other family members.[13] When they get sick, the care responsibility is hers, and this act is seen as an act of charity. In this sense, a descriptive and exploratory, qualitative, phenomenological study, executed from June to July 2010 with 15 family caregivers of dependent elderly, assisted by the Pastoral da Pessoa Idosa do Bairro Neva of Cascavel, PR, showed that 86,67% were women, which corroborates the results of this study.[14]

The care of a sick person, both in hospital and home environment, is not equally distributed among family members, and usually a person assumes greater responsibility and becomes the primary caregiver. And that caregiver's female profile is a reality in different countries, as pointed out by a study conducted in Tarragona, Spain: mostly women assume the role of family caregivers of patients, which puts them at high risk, stress and uncertainties, needing for

support in their work.[15]

In this context, it's highlighted the role of the family, considered key piece in the patient's recovery process after cardiac surgery, both during hospitalization and in the post-discharge, by being the main source of information and emotional bond with the patient - helping him to face insecurity and experienced stress. This therapeutic relationship can be maximized when there is an interest on the part of health professionals to value the emotional relationship between the family and the patient. For all this, the family is an essential element on which health professionals should focus since the advent of an illness and subsequent hospitalization of one of their members activate their needs.[16]

It's emphasized the importance of the nursing staff to understand their action beyond the patient and also including the family in their planning and care process. This favors a more effective participation in the process and enables the sharing of information that guide the development of actions focused on their understanding as the subject of the process.[17] In this context, nurses should adopt strategies to reduce stressful situations experienced by families during hospitalization, and one of the strategies is the social support tool that improves the health status and the individual well-being, in addition to acting as a protective factor in various situations.[18]

Accounting for the stress phases the patients' families were experiencing at that time, 60,5% were in the Intermediate Phase or Stress Resistance, 30,2% in Eustress or Stress Positive Phase and 9,4% in the Initial Phase or Alert. No family was in the Finals of Stress or Exhaustion.

In relation to stress phases at which the relatives of the patients in the perioperative of cardiac surgery were, it is evident that 60,5% were in the Intermediate Stress Phase also nominated Resistance Stress Phase. This phase is characterized by the fact that the body remains exposed to a high intensity stressor, therewith it tries to return to a steady state which may cause some symptoms, such as fatigue, irritability, anxiety, fear, social isolation, oscillation appetite, sexual impotence, and mood swings.[8]

Therefore, it's highlighted the importance of the role of health professionals, with emphasis on nursing in order to mobilize action towards minimizing the effects of negative stress and prevent damage to the health of these individuals. It is considered that from the moment that the multidisciplinary team, specifically nursing, recognizes the needs of the families of patients, as well as the stress experienced by them, they will be able to direct actions aimed at minimizing stress and thus qualifying assistance.[19]

In a research that studied the relationship between stress and coping of informal caregivers of seniors in situations of dependency, it was verified that the variable stress related to family life and care was what caused greater intensity of stress on caregivers, while the stress variable related to the social and economic life determined lower stress intensity.[20] This result shows that all aspects of the lives of families and caregivers must be observed by the caring staff.

After the surgery, the patients and their families face a new routine of life, a period when is required to access all the information in a clear and precise manner about the new lifestyle habits to be adopted, as an inadequate recovery of the patient can be directly related to the deficiency of information provided.[21] And, as this may be perceived as too stressful for the patient and family, the nurse must carry out the appropriate guidelines, the evaluation of absorbed guidelines and the level of understanding presented by the patients and their families.

Faced with a stressing situation the individual uses coping strategies to cope or to adapt to it. In this study, 50,94% of families used the coping style Sustaintive, in which the person uses personal, professional and spiritual support systems to address the problem, and 15.09% the Optimistic and the Confrontive, respectively.[11] Similar result was found in a survey conducted in the waiting room of the ICU, where 80 family members of patients in this unit. Such study showed that the majority (63,8%) was composed of women, married. The most frequently used coping styles were Sustaintive (57,7%) and the Optimistic (17,5%); styles less used were Fatalistic (27,5%) and Emotional (15%).[13]

Sustaintive style is related to strategies in which there are social ties and interconnections between them. Considered as social integration, this style is related to the following items of Jalowiec inventory, "talking about the problem with family or friends"; "talking about the problem with professionals such as physician, nurse, teacher, consultant"; "prays or puts his trust in God"; "talking about the problem with people who have been in similar situations" and "depend on others to get help".

In this sense, it is considered that the use of Sustaintive coping enables an approach to the stressor, since it allows the individual to seek knowledge and share experiences, thus promoting more active strategies in an attempt to lessen the impact of the stressor.[12] Furthermore, spirituality can be an important aspect, since it helps in coping and acceptance of pain and suffering, by printing some meaning to them.[22] A good relationship with God or the belief in a higher power allows the understanding and acceptance of human suffering, regardless of professed religious belief.

The Optimistic coping style was used with a representative frequency (15,9%) by the population. This style refers to the mental development and positive comparisons in an attempt to assuage the feelings arising from stressful situations. Therefore, defensive and problem distancing processes are used, focusing the action on the adjustment or replacement of the emotional impact of stress.[12] Confrontive coping was used by 15.9% of the family, which means that the family faced the stressor event in a combative manner, confronting the stressful situation.

Considering the prevalent coping styles for the study

population (sustaintive, optimistic and confrontive), it was decided to analyze them from the focus of action proposed by Lazarus and Folkman, namely: emotion and problem.[7] The eight coping styles proposed by Jalowiec can be classified into coping focused on problem (confrontive, evasive, and self-confident) and coping with a focus on emotion (emotive, palliative, optimistic and fatalistic). In the analysis of coping styles listed by the individuals of this study in the management of stressor in question, we got a coping predominantly focused on the problem - a positive data as it shows that families are facing stressors when seeking to minimize suffering.

From the analysis of the results presented at the intersection of coping styles related to the stress stages which the family members surveyed were at, it is inferred that coping styles used by family members were effective, given that the family were at the three early stages of stress and none in the Final Stage or Exhaustion. Given this result, it is emphasized that the family used coping strategies focused on the problem, but also used the strategies focused on emotion. Thus, choosing one strategy or another may be complementary, being that the focused coping emotion may facilitate the problem focused coping, alleviate stress, while similarly problem focused coping can reduce the threat and, therefore, reduce the emotional tension.[12]

In this perspective, it is important that health professionals observe the reactions of these families, because at the time of the procedure they were outside the operating room and experiencing a concrete situation of anxiety, doubts and fears, which requires adaptation and possible problem solving attitudes. The coping style used by most families, the sustaintive, translates the demand, request and search for help. Thus, the nurse, both in the operating room as in the Coronary ICU, can act to ensure such support and identify the needs through dialogue, listening and guidance that can contribute to knowledge and improve the skills required for these people to face a stressful situation.

In this respect, it is highlighted the need for an easier interaction with patients and families, since the health work is a listening exercise and attention directed to comprehensive care, aimed to healthcare quality.[23] Given this reality, it is understood that the health care is developed in a context in which the human relationship is a major factor, able to offer security and emotional support to both patients and their families.

CONCLUSION

Respondent families experienced the stress and used coping strategies to deal with it. Therefore, it is important that professionals involved in the care recognize this and seek to assist them, knowing that, also in relation to the patients in the perioperative cardiac surgery, family members need to be maintained.

The coping process refers to the assessment of how the phenomenon is perceived, interpreted and cognitively represented in the individual's mind. Thus, the nurse can help the families to minimize the stressors and assist them towards more resolving coping strategies - enabling them to act more actively in the process of monitoring patients during heart surgery. Thus, identifying and assessing stress and coping of the patients' families becomes essential for nursing, in the sense that these results can support the work of these professionals for the implementation of humanized care - which aims to assist patients and families in their specificities and promote wellness.

The relevance of this research is given by the opportunity of the results to subsidize health professionals, researchers and managers, mobilize integrated actions to qualify assistance in the perioperative period, with emphasis on care to patients and families. The nurse can perform various actions, such as: conversation circles in which participants can express their doubts, make inquiries that foster nurses to inform families about the patients' conditio; guide their staff about stress, the damage it can cause to health and, in this context, highlight the importance of directing actions to the family. The knowledge produced in this study confirms the importance of developing a focused assistance not only for the patient but also for their family.

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